

Abstract

We investigated human rights concerns related to migration, living and working conditions, and access to HIV/AIDS services and reproductive health services for Burmese women in Thailand. Vulnerability to HIV/AIDS for Burmese women stemmed from abuses they experienced: gender and ethnic discrimination, including violence; unsafe migration and trafficking; labor and sexual exploitation; and denial of health care. Despite having bound itself to human rights laws, the Thai government is failing to fulfill its obligations to Burmese women, with particularly devastating impacts for their well-being, including the risk of HIV/AIDS. Moreover, as our documentation shows, this failure to incorporate human rights concerns into its national response to the epidemic virtually guarantees that HIV/AIDS will continue to be a problem in Thailand.

Nous avons examiné les problèmes des droits de l'homme en relation avec la migration, les conditions de vie et de travail et l'accès aux services de santé relatifs au VIH/SIDA et à ceux de la reproduction des femmes birmanes en Thaïlande. La vulnérabilité des femmes birmanes au VIH/SIDA provient des abus dont elles sont victimes: discrimination sexuelle et ethnique, y compris violence; migration à haut risque et trafic de personnes; exploitation sexuelle et au travail; refus de soins médicaux. Malgré son accord avec les lois sur les droits de l'homme, le gouvernement de la Thaïlande manque à ces obligations envers les femmes birmanes, avec des conséquences dévastatrices sur leur bien-être, y compris le risque du VIH/SIDA. De plus, notre documentation montre que cet échec d'incorporer les problèmes des droits de l'homme à sa réponse nationale à l'épidémie garantit que le VIH/SIDA continuera d'être un problème en Thaïlande.

Investigamos temas en cuanto a derechos humanos relacionadas con migración, condiciones de vida y laborales así como acceso a servicios para personas con infección de VIH/SIDA y los servicios para la salud reproductiva para mujeres birmanas en Tailandia. La vulnerabilidad a infección por VIH/SIDA para mujeres birmanas se derivó de los abusos que experimentaron: discriminación de género y étnica, incluso violencia; migración y tráfico inseguros; explotación laboral y sexual, y negación de cuidado de la salud. A pesar de haberse sometido a las leyes de los derechos humanos, el gobierno tailandés no está cumpliendo con sus obligaciones con las mujeres birmanas, con repercusiones en particular devastadoras para su bienestar, incluso el riesgo de infección por VIH/SIDA. Más aún, como lo muestra nuestra documentación, este fracaso para incorporar temas respecto a derechos humanos en su respuesta nacional a la epidemia virtualmente asegura que la infección por VIH/SIDA seguirá siendo un problema en Tailandia.

HUMAN RIGHTS ABUSES AND VULNERABILITY TO HIV/AIDS: The Experiences of Burmese Women in Thailand

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Recognition of the human rights dimensions of the HIV/AIDS epidemic has evolved over time, from concern with the protection of individuals, such as assuring confidentiality in testing, to the identification of human rights abuses, such as gender-based discrimination, as drivers of the global epidemic in specific marginalized populations. In 2001, the UN General Assembly adopted a Declaration of Commitment on HIV/AIDS, stating that “. . . the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic. . . .”¹

There are two relevant dimensions to a health and human rights analysis of a comprehensive response: 1) identifying the health consequences of human rights violations, for example, HIV infection; and 2) analyzing the human rights impacts of government policies in health and other sectors, such as immigration.² Underpinning this assessment is the understanding that health and human rights are intrinsically intertwined: health is necessary for the exercise of

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rights, and the realization of human rights is a necessary precondition for health.³

Burmese women in Thailand, many of whom are fleeing from violence and deprivation in Burma, are subject to numerous human rights abuses during migration and upon arrival. These abuses, largely based on gender and undocumented residency status, create vulnerability to HIV through compelled sexual risk-taking as well as denying these women access to prevention, care, and treatment. The Thai government's failure to take the rights of this population into account, in particular in the highly vaunted national AIDS prevention campaign and the worker registration schemes, amounts to further abuses, with resulting detrimental impacts on Burmese women's well-being.

Background

Thailand has been hailed as an HIV/AIDS success story due to the changes in sexual behavior and reduction in prevalence resulting from its national AIDS strategy.^{4,5} That program, however, neglected the most vulnerable populations—in particular, Burmese migrant women living in Thailand.

Although the number of migrants in Thailand is unknown, the great majority hail from Burma, one of the world's least developed nations, which is ruled by a junta notorious for its human rights abuses, particularly of ethnic minorities, including campaigns of forced conscription and systematic rape of women.⁶ Over one million Burmese were believed to live in Thailand in 2004, one of the largest migrant movements in southeast Asia.⁷ Many Burmese migrants leave a context of severe human rights abrogation and acute economic hardship to migrate to Thailand, where they experience further human rights abuses perpetrated by job brokers and employers; immigration, police, and other government officials; and others, due to their lack of legal status. These human rights abuses have severe health impacts, including transmission of the HIV virus.

In sentinel surveillance of high-risk groups, the highest infection rates have been found in Burma's cross-border points with Thailand, especially among the Shans.⁸⁻¹¹ In one assessment, the HIV prevalence for Shan was 3.0% for

women and 9.0% for men, one of the highest reported in Asia for any ethnic group.¹² Another prevalence study done in 1999 among ethnic Shan migrant workers in the Chiang Mai area revealed an HIV prevalence of 4.9% (5.7% for men and 3.8% for women), almost double that of comparable local Thai populations at the time.¹³

The situation of Burmese migrants is compounded, moreover, by the denial of labor protections and health services provided to Thai citizens and documented migrants. Since the early 1990s, Burmese have formed a cornerstone of the Thai economy, particularly in the “3D” jobs (dirty, dangerous, and disdained). These include jobs in the illegal but tolerated and lucrative commercial sex industry, estimated to generate about 40 billion baht annually (approximately US\$1 billion).^{14,15} Estimates vary, but there are thought to be 200,000–325,000 sex workers in Thailand, of whom 30,000–80,000 are estimated to be undocumented migrants, the majority of whom are Burmese women.^{16–19} HIV prevalence is higher among Burmese sex workers than among Thai sex workers, in part due to their likelihood of having suffered the sexual risks associated with having been coerced or trafficked into sex work, as well as the fact that riskier low-end work is almost exclusively the province of non-Thai women.^{20–22}

Since the early 1990s, Thailand has implemented a foreign worker registration system permitting employers to register and legalize foreign migrants for an annual fee in some sectors, such as manufacturing, as guest workers for one year, a status which technically provides access to the universal health care coverage plan.²³ The vast majority of Burmese migrants in Thailand are unregistered, however, due to the ineligibility of their occupations, their fear of arrest or deportation if they attempt to register, the dependence on a single employer created by the system, and the weakness in practice of labor protections for non-Thais.^{24, 25}

A critical discriminatory aspect of the migration and worker registration policies is the denial of HIV-related education and services. In 1991, Thailand initiated a national program to coordinate HIV prevention, testing, treatment, and care efforts.²⁶ A crucial part of the program, and critical to Thailand’s success in controlling its HIV/AIDS epidemic, was the “100% Condom Campaign,” targeted at commercial

sex establishments and their patrons.²⁷ Despite the nominal illegality of sex work, the campaign was a collaborative effort by a range of public agencies and private businesses, including the Ministry of Public Health, the Royal Thai Police, and brothel owners. Access to commercial sex venues by visiting public health nurses was twinned with a program to encourage regular visits by sex workers to sexually transmitted infection (STI) clinics.^{28,29} The campaign resulted in a decline in HIV prevalence and reductions in risky behavior, and sharply decreased STI consultations.³⁰⁻³² The health services it provided were limited, however, and its narrow target ignored the majority of the non-Thai population.

Moreover, the campaign failed to reach the trafficked and/or lowest-end, brothel-based workers, since commercial sex venues with the worst conditions may be the least known to public health authorities, and thus the most inaccessible. Burmese women have limited Thai language skills and fear arrest for their undocumented status; as a result, they are likely to be in the most restrictive venues where owners may not permit them to leave the premises or go unaccompanied to STI clinics.^{33,34} Unemployed Burmese migrant women or those working in other sectors are denied even these limited HIV-related health services. The failure of the Thai government to include this population in its national AIDS policy perpetuates the negative consequences of the limited health services and HIV prevention education made available to these populations in Burma by the Burmese regime.³⁵

Methods and Subject Sampling

In 2004, Physicians for Human Rights (PHR) conducted an investigation into the vulnerability to HIV/AIDS of Burmese women in Thailand. The goal of the study was to identify human rights concerns related to migration and undocumented status and make remedial policy recommendations. A qualitative assessment was designed to elicit and understand the human rights abuses suffered by Burmese migrants in Thailand; identify the factors, conditions, and practices that facilitated the trafficking and exploitation of these individuals; assess the health consequences, including HIV/AIDS, of such conditions and practices; understand the

relationship of the commercial sex sector and sexual exploitation to trafficking and other forms of unsafe migration, as well as HIV/AIDS; describe and assess government responses; and formulate recommendations with study participants to ensure the health and human rights of affected women.

Interviews were conducted to document 1) testimonies from women with direct experience of trafficking and other forms of unsafe migration, exploitative labor, or sexual exploitation, and 2) information from local nongovernmental organization (NGO) representatives and volunteers, fieldworkers and researchers from international agencies, policymakers, academics, and government officials.³⁶ Respondents represented a wide spectrum of backgrounds and opinions, including law enforcement, labor, health and social services, immigration, and community empowerment. The interview instruments consisted of a series of semi-structured questions designed to elicit the participants' attitudes and experiences, in the case of affected individuals, or expertise, in the case of key informants. Remedial recommendations were solicited from both groups. Interviews were conducted in English, Burmese, Shan, or Thai and translated as needed. Individuals under age 18 were not interviewed for the study.

Based on a literature review and background interviews with experts on trafficking and migration routes and the geographic areas in which some of the most exploited persons are located, interviews were conducted in Bangkok, Mae Sot (central west Thailand on the Burmese border), and Chiang Mai (in the northern region of Thailand). In identifying key informants to obtain a broad scope and depth of information and perspectives, the researchers sampled a range of organizations and individuals working in public health and health-care, anti-trafficking, migration, law enforcement, government, HIV/AIDS research and activism, assistance to women and girls in sex work, and refugee, ethnic minority, and Burmese communities. Individual women with direct experience of trafficking and other forms of unsafe migration, exploitative labor, or sexual exploitation were introduced to researchers by representatives of local organizations that provide services and protect and promote their rights and/or well-being. Key informants were identified by chain

(snowball) sampling. Researchers conducted 68 key informant interviews (many with more than one organizational representative) and collected 34 individual narratives.

This research was conducted in accordance with the Declaration of Helsinki (as revised in 2000) and reviewed and approved by a PHR Ethics Review Board, a group of individuals with expertise in public health, clinical medicine, bioethics, refugee and migrant populations, and international human rights research. The Committee on Human Research of the Johns Hopkins Bloomberg School of Public Health agreed to accept the review of this independent ethics panel and concurred with its approval. All participants were informed of the purpose of the interview, its voluntary nature, and the ways in which the data would be collected and used. All verbally consented to be interviewed. Participants who requested confidentiality or who spoke “off the record,” were assured that their names and other identifying factors, or the name of their organization, would not be used and would be kept separately from the data collected. Participants did not receive any material compensation. No names are used in the accounts of individual experiences.

In the findings that follow, the exact (translated) words of participants are used where possible to give full expression to their opinions and narratives.

A descriptive and analytic framework was adapted from the five stages of trafficking/migration model developed by Zimmerman, and others.³⁷ Briefly, the stages are 1) pre-departure, including structural and environmental contexts driving migration; 2) transit and travel to destinations; 3) exploitation at destination; 4) removal from trafficked situations, which can include detention; and 5) repatriation and re-integration. The investigation and this analysis focus on the first three stages, as security and resource considerations precluded investigation of stages four and five.

Results

Pre-Departure: Antecedents to Migration

Respondents reported consistent motifs of migrants taking risks in going to Thailand to escape poverty and/or terror in Burma, seek a livelihood to send money home, or,

less frequently, pursue educational opportunities. Said one group of women:

Life in Burma now is impossible. Both the Burmese armies, police and local armies, are always taking something from us. We have no freedom to work, grow rice, or move around. There are no medicines and no doctors. No schools. Nothing . . . We would like the Thai government to talk honestly about Burma and stop making business deals with [the Burmese junta].³⁸

In some population source areas in Shan and Kachin States, ethnic minority populations are being forced to relocate when their land is taken for population resettlement for the Wa ethnic group (allies of the ruling regime) and for Chinese immigrants who can pay resettlement fees.³⁹ As a result, in areas in Shan State, for example, where forced population transfers have been documented, economic matters have become particularly challenging.⁴⁰ Noted Nang Hseng Nong and Nang Pi of the Shan Women's Action Network (SWAN):

Twenty military or a whole company will come and steal the harvest. The military asks them to grow opium and taxes them like they did with the rice, at a fixed weight, whether there's a good or bad crop, so they have to buy from others to pay. No one can survive.⁴¹

Others were forced to flee to Thailand because of political and/or security concerns. One woman interviewed was from a politically active family from Rangoon. Her father was a leader in the National League for Democracy and was jailed for his activities several years ago. After his arrest, Burmese internal security agents frequently came to their house, usually late at night. Her mother was very afraid of the raids and became concerned for her daughter's safety, finally fleeing to Thailand with her children.⁴²

Most Burmese ultimately want to return home. Many go back and forth if they can, given Burma's political, social, and economic crisis. Noted one respondent:

Burma is our home, where our family is, where our lives are We come back to Thailand because Burma is still a place where we cannot provide for our families;

that has not changed just because we left for a while. When the money we earned runs out, we come back to earn more. Sometimes we come back earlier because we need money to pay off the military so our families will be safe from forced labor, conscription, or rape.⁴³

Migration from Burma to Thailand

Burma shares a border with Thailand measuring over 2,000 km (1,250 miles). The border is porous; crossing it often simply involves crossing a river, taking a bus, or walking. Cross-border migration from Burma to Thailand is best understood in the context of the many Burmese heading to Thailand as refugees, asylum seekers, or voluntary, irregular migrants, with trafficking across national borders being far less frequent in our findings. A central theme was that the more information and ability to tap into an existing social network that an individual had in leaving Burma, the safer she would be. Noted one NGO providing workplace trainings and a drop-in center for women migrants in Mae Sot:

There are four ways that women come to Thailand and find work [in factories in Mae Sot]: (1) A friend asks the owner, and they call to Burma and say you can come; (2) People without contacts or knowledge arrive at the market or bus station. This is the more difficult or dangerous way. They look for friends from the same village to stay in a room with; (3) Sometimes they pay a broker; (4) The owner pays the broker, so the worker doesn't get paid for three months. They get into debt, so the [other] women [workers] help each other out with money.⁴⁴

Several NGO workers active with migrant populations spoke about the importance of smuggling, or paid brokerage, for migration from Burma to Thailand. In the Shan State — Fang District Thailand border areas, large numbers of new migrants come every month from Burma into Thailand, particularly to work in the large citrus groves, and they generally have to pay brokers and/or smugglers who have contacts with the police.⁴⁵ Once across, migrants take motorcycle rides from established river/mountain crossing sites, bypassing the checkpoints on the main roads. These rides

can cost them up to 1,500 baht (US\$38) to travel a few kilometers into Thailand.⁴⁶

One NGO worker stressed the dangers of traveling without smugglers or brokers. He described a client whom his organization was assisting, a 15 year-old Pa-O boy who was the sole survivor of an incident that occurred in early 2004 in Shan State, about 10 kilometers inside Burma. In this case, six migrants, including the 15-year-old, were attempting to cross into Thailand without using an agent. They unknowingly entered a minefield, and five of the six were killed in a subsequent explosion.⁴⁷

Participants reported trafficking in migration from Burma to Thailand, most often for work. Trafficking situations often began with the decision to migrate to Thailand, and then deteriorated into trafficking as the migrant became afraid, vulnerable to exploitation, and easily intimidated and deceived. Usually she did not realize her situation until she arrived at her destination.^{48,49} Noted one crisis support center worker:

We see a lot of housekeeper cases; women know [what they will be doing] and want this job even though it's low-paying, because they'll have a place to live and food—but without ID there's threats and lots of cheating. . . . They agree to work as maids, and think they will get paid and don't know that the agent [who brokered the job] took [three months of] the salary. There were two girls, 18 and 20 years old. This is typical, that after three to four months the trafficker will move them to another house, on the same terms, so the women never get paid. They escaped somehow and got in touch with us.⁵⁰

According to our interviews, this form of trafficking was more common along the northern route. Migrants from Shan State were particularly vulnerable to trafficking and unsafe migration from Burma because, in contrast to the situation with the Karen and Karenni people, there are no formal refugee camps for the Shan in Thailand. Many came from forced relocation areas around Kengtung, near the Thailand crossing at Mae Sai. In one such area, the Shan population had reportedly decreased from roughly 12,000 to 3,000, becoming an ethnic minority in a traditional Shan homeland.⁵¹

Furthermore, Shan women were at particular risk for rape and sexual assault from Burmese military forces when in transit across conflict zones in Shan State.⁵²

Getting from the border areas to the major towns and cities deeper into Thailand was much more difficult than getting to Thailand from Burma. The relatively few paved roads and rail and air routes in the area were heavily monitored, with multiple checkpoints and patrols. Although bribes could facilitate crossing checkpoints, these were expensive.⁵³ In addition, migrants who took the “jungle roads” to avoid checkpoints faced other dangers, including gangs who preyed on migrants.⁵⁴

Exploitation in Thailand: Conditions of Work, Sexual Exploitation, Access to Health Services

Many key informants working with Burmese migrant women in Thailand underscored the fact that female migrants and trafficked women faced “exactly the same” issues in terms of exploitation at their destination, including sexual abuse, debt bondage and the transfer of debts to new employers, concerns over personal physical security, harsh living conditions, and lack of access to health care.⁵⁵

NGO staff working with Burmese migrants reported highly exploitative factory work in Thailand. A Burmese community leader noted a substantial increase in the number of factories and Burmese migrants since 2000 because of the deterioration of the economy in Burma.⁵⁶ At the time of the investigation, there were approximately 200–300 factories in Mae Sot, with the largest employing 2,000–3,000 workers. With so many migrants available, workers were treated worse than at factories elsewhere in Thailand and received lower salaries.^{57, 58} The majority (75–85%) of these workers were women. Staff from several Burmese community NGOs said that this was due to the fact that factory owners found women to be “quiet and compliant” and easier to control than men.⁵⁹

As recounted by many respondents, the work was hard and conditions were harsh. A typical work day lasted from 8 a.m. to 9 p.m., with one day off per month, usually the day after payday. Workers earned 50–80 baht (US\$1.50–\$2.00) per day (the minimum wage for Mae Sot as of January 2004

was 135 baht [US\$3.30] per day). Employers claimed that they paid less because they provided accommodation, but they deducted from the workers' wages for the work permit (300–500 baht, or US\$7–\$12) and for shelter and food (500 baht or US\$12 per month).⁶⁰ Workers were often confined to the factory; even if they were able to leave, their mobility was limited. Occasionally, they were subjected to physical violence, such as beatings from Thai gangs when they ventured outside; in Mae Sot, at least 20 cases of rape or murder committed against migrants were reported to police each year, all of which went unpunished.⁶¹ These cases underscore Burmese women's lack of access to legal protections and emergency services, such as post-rape emergency contraception and post-exposure prophylaxis to prevent HIV infection, all of which are available to Thai women after rape.

It was widely reported that workers were given only a copy of their work permit and never saw the original, which was required to access benefits, such as the government's health care plan, as well as to show to police to prove temporary legal status in Thailand. Meanwhile, the worker's pay was docked every month for the registration fee on an indefinite basis. In addition, because taxes are linked to the number of workers a factory has, some factories registered only half of their workers. If a worker left, factory owners altered the working papers for a new worker, leaving both workers without legal documentation. Without this documentation, they had no legal protection and were therefore both subject to deportation.⁶²

Many dangers faced Burmese migrants within factories. Safety issues were often overlooked, resulting in workplace-related injuries. One Burmese migrant recounted that one stainless steel plate factory did not provide earplugs, causing hearing problems for the workers as a result of the noisy environment.⁶³ Sexual harassment and abuse by the male members of factory owners' families and by the (Thai) factory assistants and security guards were often reported. In one instance, a woman raped by an assistant had this reported to the wife of the factory owner in Bangkok, and the result was that the woman was dismissed.⁶⁴

Abuses were also experienced by women employed in commercial sex venues. One woman in Mae Sot described

the conditions as follows: clients were charged 500 baht per hour (about US\$13), of which the women were supposed to receive 50 percent. Each woman had to pay the owner 1,900 baht (US\$47) per month. If the woman was sick and could not work (including during menstruation), she was fined 500 baht (US\$12.50) for each client who asked for her; a woman who was sick could be fined over 4,000 baht (close to US\$100) in a day.⁶⁵ Practices such as these encouraged women with illnesses to continue working; women with symptomatic STIs and other genital lesions who continued to work under these circumstances markedly increased their risk of HIV acquisition.^{66–70} The women also had to pay 500 baht (US\$12.50) per month each to the police: “[t]hese are not traffic police, they are more powerful. . . same as immigration,” noted one of the participants.⁷¹

Exploitation and trafficking of Burmese women into sex work by Thai law enforcement officials was noted by several of those interviewed. A neighbor of a Mae Sot brothel recounted that the women’s greatest fear is “working for free,” providing sexual services for Thai police and soldiers.⁷² Another respondent recounted the situation in a Mae Sot restaurant where sex was sold. The owner was a colonel in Thai Immigration. According to the respondent, many higher ranking officers visited from Bangkok and wanted “good food and good women. . . . They want different nationalities [not Thai].” The restaurant had the reputation for offering sex with virgins: 8,000 baht [US\$200] for *pakin pwin* [Burmese for “to open the package”] and 5,000 baht [US\$125] “if she is not beautiful.”⁷³ Several respondents also noted that immigration officials trafficked women into commercial sex venues after they were detained in the Immigration Detention Center in Mae Sot, where women are brought from all over Thailand for deportation. Police also allegedly sold women into debt bondage in commercial sex venues from detention at the Mae Sot police station.⁷⁴

Interviews revealed that access to basic health care was generally lacking for Burmese migrants in Thailand, especially with regard to reproductive health. Lack of contraceptive access was also a recurring theme; NGO workers noted a lack of condom availability despite international donor aid

providing for these services for migrants in Thailand. Arrest, and fear of arrest, at the many security checkpoints also posed a barrier for individuals seeking care. Patients being transported to the hospital by NGO workers were detained by police and had to be “bailed out” with bribes.⁷⁵ One physician attributed low rates of women receiving clinic-based antenatal care who returned for delivery (30–40%) to issues of access, including security and the cost of transport.⁷⁶

NGOs working with Burmese migrant factory workers also reported the workers’ poor access to health care. It was very difficult for workers to get sick leave. Furthermore, short-term relationships resulting from co-ed housing conditions often led to unintended pregnancies. If women became pregnant, they often lost their jobs: pregnant migrants are often fired from jobs, especially construction sites. Access to reproductive services is very limited, and condom supplies have decreased, so many women choose unsafe abortion to avoid pregnancy and keep working.⁷⁷ Pregnant workers often tried to do home abortions, which commonly resulted in localized infections, sepsis, other complications, and sometimes death.⁷⁸ Many women carried their pregnancies to term and then, unable to care for the child due to their financial or work circumstances and/or the stigma of single motherhood, abandoned the child at a hospital, clinic, or safe house. The authors observed a number of these stateless children in Mae Sot, living at NGO-run facilities for an indefinite time.

Several health outreach projects targeted factories in Mae Sot, but access to factories required the permission of owners, who often did not allow time for workers to receive information or refused access altogether.⁷⁹

Although public health services had been available for sex workers in both Chiang Mai and Mae Sot since the early 1990s, women may not have always been able to access these services. In Chiang Mai, a woman reported that if women at the brothel where she was debt-bonded were sick, they would not be sent to clinic or hospital, but had to buy medicine themselves. If they became ill with AIDS, they were immediately forced to leave without care or support.⁸⁰ Mae Sot Provincial Hospital had a designated clinic

for sex workers that served both Thai and Burmese women, most of whom worked in bars, pubs, restaurants, and karaoke lounges, with few working in traditional brothels. While STIs were generally not common, the diagnoses most frequently made at the STI clinic were herpes lesions and HIV infection.⁸¹ Data provided by Mae Sot Hospital detailed the breakdown of STIs at the clinic by ethnicity and diagnosis from 2001–2003. Out of 104 patients seen in 2003, all were Burmese, and none were covered by the Thai government health plan. The clinic reported that 14% had HIV/AIDS.⁸²

Mae Sot Hospital reported that attendance at the sex worker clinic had declined sharply since the Thai government began its crackdown on sex venues in 2004, as part of the “Social Order Campaign.” Public health visits to commercial sex venues in Mae Sot suggested no decline in the number of venues or workers, however.⁸³ This discrepancy is likely explained by declines in access to STI services for Burmese sex workers as a direct result of the Thai policy. Those able to access the clinic faced additional challenges. Workers with one of the health outreach projects reported instances in which sex workers who had tested positive for HIV at the health checks were fired by their employers. The patients, who had not been informed of their HIV status, were unaware that their employers had been informed of the test results by the hospital.⁸⁴

Compounding problems of lack of access to care were the low levels of knowledge among Burmese women in Thailand regarding HIV infection.⁸⁵ HIV was typically diagnosed in advanced stages, when patients were too ill or weak to work. Many lacked relatives to support them. Employers generally abandoned HIV-positive workers at the local hospital. Hospitals did not want to take care of undocumented migrants with AIDS and often turned to Burmese NGOs to provide palliative care.^{86,87}

In addition to health care, unregistered Burmese-run NGOs and (many undocumented) Burmese workers at Thai and Burmese NGOs provided Burmese women in Thailand with other essential services. These services included working with trafficked persons and migrants in crisis, providing primary care and HIV and reproductive health educa-

tion and services, engaging in women's and/or migrant workers' rights advocacy and empowerment, and providing education. Given the problems that these women faced, however, and the lack of support from employers and the Thai government, the NGOs' work was not sufficient.

These organizations and their volunteers and staff also faced the same challenges that Burmese women faced in Thailand. In particular, in 2004, local authorities had been directed by the government to vigorously enforce the section of the immigration law against "harboring" undocumented migrants, announcing a 20,000 baht (US\$500) penalty and jail time for violators.⁸⁸ Landlords, employers, and shopkeepers, as well as NGO workers, had been threatened with this provision by neighbors and police. As a result, homelessness among migrants increased, NGOs had their situations made unstable by nervous landlords, and Burmese vendors and others who depended on the income generated from migrant workers' spending were negatively affected.⁸⁹ The vagueness of the prohibition also allowed for much official abuse. Noted one key informant:

There were two women living together, one had a work permit and one didn't. They were raided by the police and taken into custody. The one without the permit was let go after two to three days. The one with the permit was charged with harboring and spent two-and-a-half months in jail and was fined 5,000 baht (\$125). The police demanded money [from her], searched her vagina for money and cut her [long] hair [to humiliate her]. She had to go to [a] hospital for bodily injury from the search.⁹⁰

Discussion

This study was designed to provide critical insight into the manner in which human rights violations committed against Burmese migrant women in Thailand renders them vulnerable to trafficking and other forms of unsafe migration, exploitative labor, and sexual exploitation, and consequently, through these additional violations, to HIV/AIDS. Desperation arising from poverty and widespread abuses at home drove the participants to migrate to Thailand; this journey, coupled with the lack of legal status and labor under exploitative conditions in the host country, including

in the sex industry, imperiled the health of Burmese migrant women, including increasing their risk of HIV/AIDS. The Thai government's abdication of responsibility for uncorrupted and non-discriminatory law enforcement and human rights protection allowed abuses to continue unchecked and reinforced the patterns of exploitation. These exploitative conditions were frequently tolerated, as migrants often felt them preferable to the violence, chaos, and socioeconomic deprivation they would experience if deported to Burma.

Finally, discriminatory barriers to health services deprived Burmese women of prevention, care, and treatment for HIV/AIDS and other sexual and reproductive health impacts of the abuses they suffered, multiplying the impacts of the harms they experienced. The study findings thus indicate that denial of full legal status, gender discrimination, and ethnic discrimination are underlying causes giving rise to the vulnerability to HIV in this population.

This study has several major limitations. Given the difficulty accessing affected women as a result of security concerns and the intimate and often stigmatized nature of their experiences, the findings of the investigation are not intended to represent the attitudes and experience of all migrant women in Thailand, nor was the study able to establish causal associations. In addition, because of time and resource limitations and security issues, researchers were unable to travel to the south of Thailand; this study does not reflect the experiences of the significant population of Burmese migrants living there. In the context of similar testimonies collected by others, however, the narrations collected provide considerable insight into the patterns and human rights dimensions of Burmese migrant women's experiences.

Thailand has acceded to, signed, or ratified several international instruments that legally bind the government to protect the panoply of rights for all individuals who live in Thailand, regardless of citizenship status. These include the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of Discrimination Against Women, and 13 International Labor Organization conventions, including the Employment Policy Convention and

the Abolition of Forced Labor Convention, which require Thailand to grant protections to all workers equally under Thai labor law, regardless of legal status.^{91–95} Moreover, Thailand signed the International Trafficking Protocol in 2001 and has acceded to the Convention against Transnational Organized Crime.⁹⁶ Under these laws, Thailand is required to, among other obligations, respect, protect, promote, and fulfill the right to life, personal security, information, work, health and equality, and the norm of non-discrimination.^{97–103}

This article has presented evidence of Thailand's violation of its obligations under international human rights law. Burmese women experienced life-threatening abuses in Thailand, including exposure to reproductive health risks, such as unintended pregnancy and HIV infection, and lack of treatment for pregnancy or abortion complications or AIDS. They reported frequently living in a state of personal physical insecurity, whether in factories, the houses of domestic employers, sex work venues, or on public streets while traveling. These threatening situations frequently led to sexual abuse or exploitation that resulted in devastating health consequences. The lack of information regarding HIV prevention and other health risks, as well as the absence of educational materials and resources needed to profit from the worker registration scheme, also led to exploitation and vulnerability to HIV and other forms of ill health.

By all accounts, many Burmese women are forced to migrate frequently, both between Burma and Thailand and within Thailand itself, risking again and again the abuses perpetrated by smugglers, traffickers, employers, and corrupt officials, who operate with impunity in the country. Women migrants are poorly paid, harassed, employed in settings with few protections for workers, subject to sexual and other forms of violence, restricted in their movements, and denied the family planning, reproductive health, and antenatal care they are due, regardless of immigration status. The national HIV policy is only one of a host of policies—trafficking, migration, public health, and labor are some of the others—that ignore the needs and rights of this vulnerable population and contribute to its acute discrimination and further marginalization.

Conclusion

The lack of basic human rights of Burmese women migrants provides a case study of the ways in which denial of rights can have a negative impact on well-being, including access to health care and vulnerability to disease, especially HIV/AIDS. Despite a program widely hailed as a model for HIV prevention in the region, the failure of the Thai government to promote and protect the rights of Burmese women in Thailand, and to take measures to reduce their vulnerabilities to human rights abuses, increases their risk of HIV infection. The failure to reach these vulnerable communities is not only a failure of human rights; it undermines the gains achieved by the Thai AIDS program and is a virtual assurance that HIV/AIDS will continue to be a problem for Thailand.

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